Bloodborne Pathogens Exposure Policy and Procedures

Employees of the State of South Dakota

Department of Health

Bloodborne Pathogens

(HIV, HBV, and HCV)

Exposure Management

PEP Hotline 1-888-448-4911
DOH Hotline 1-800-592-1861

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Appendices

Attachment

South Dakota Department of Health
Administrative Policies and Procedures

STATEMENT NO. 51
TITLE: Personnel – Bloodborne Pathogens Exposure
ISSUED: April 14, 2003
REVISED: July 28, 2003

In the interest of the health and safety of employees, patients and clients, all needle-stick, puncture wounds and exposure to mucocutaneous blood and/or body fluid must be reported as specified by *Administrative Policy and Procedure Statement No. 65*.

In addition, individual occurrences will be managed in accordance with the state's post-exposure protocol (available through the Office of the Secretary of Health). This includes all occurrences experienced by Department of Health employees and patients or clients of the department.

All supervisors whose employees are subject to needle-sticks, puncture wounds and exposure to body fluids will make this policy available to their employees upon appointment.

Introduction
Bloodborne Exposure Management

Employees may be reluctant to report occupational risk exposures for a variety of reasons, however immediate medical management is vital for the following reasons:

1. Immediate reporting allows time for you and your physician to discuss anti-viral treatment risks/benefits.

2. Anti-viral treatment has been shown to decrease the rate of HIV seroconversions following occupational exposures by 79% if initiated within 1-2 hours. As time goes by, the potential effectiveness of anti-viral medications preventing HIV infection decreases.

3. If after 36 hours anti-viral medications have not been initiated, they are not recommended except in extreme circumstances.

4. Post exposure prophylaxis management for Hepatitis B is also available, and should be considered.

5. The appropriate forms are required to claim worker's compensation benefits for the post exposure follow up. These benefits may include potential medical benefits.

Medical Management of Bloodborne Exposures
Policy and Procedure

1. Any employee with a significant bloodborne exposure should immediately wash or flush the exposed area and be immediately directed to the nearest emergency room for assessment and treatment.

2. If possible have the employee bring the "Quick Guide" (Attachment #1) with them to the emergency room. (Do not delay employee's departure for this task)

3. The exposure may be assessed in consultation with the employee's personal physician so long as it does not result in an unreasonable delay.

4. Decisions regarding the initiation of post exposure prophylaxis (PEP) should be made by the employee, and the medical provider.

5. Decisions regarding post exposure prophylaxis for Hepatitis B should be made using the algorithm for Hepatitis B prophylaxis ("Quick Guide" – Attachment #1). If an employee refuses the recommended Hepatitis B post exposure management, then a baseline Hepatitis B surface antigen test should be done and repeated in 6 months.

6. Testing of the employee and the source of the exposure (if a person) is strongly recommended when a significant bloodborne exposure has occurred. **Regardless of the potential risk, the employee has the right to request or refuse testing**. The exposure to the employee should be explained to the source person and testing requested. The source person cannot be tested without consent, except under the circumstances described in SDCL 23A-35B (laws dealing with sexual assault and exposure to law enforcement personnel)

7. If the source person chooses to be tested, he/she must give written consent by using the "Request for Testing Form" (Form #4) or similar type consent form.

8. The physician may request that the source person's name be checked with the South Dakota Department of Health for reports of bloodborne pathogens. The source person's test results may be released to the physician to assist in medical management decisions.

9. The employee may choose to have a baseline test at the time of the exposure, but held and not tested until the source person's test results are known.

10. The "Occupational Risk Exposure Report Form" (Form #1) is available to be used.

11. Notify the next level supervisor.

12. Complete the "South Dakota Employer's First Report of Injury" and the "Employee's Accident Report" forms within seven (7) business days of the exposure. (Forms #5 and #6)

Definition of a Significant Bloodborne Exposure

An exposure to blood or potentially infectious body fluid through:

1. Percutaneous (needlestick, puncture or cut by an object through the skin);
2. Mucous membrane (exposure to the eyes, mouth, nasal, etc); or
3. Non-intact skin (exposure to blood or other potentially infectious body fluids).

Other infectious or potentially infectious body fluids include:

1. Semen
2. Vaginal secretions
3. Any body fluid visibly contaminated with blood
4. Human tissues (including dental extractions)

A significant bloodborne exposure is an exposure to blood or potentially infectious body fluid through:

1. Needle stick, puncture or cut by an object through the skin;
2. Direct contact of mucous membrane (eyes, mouth, nasal, etc);
3. Exposure of broken skin to blood or other potentially infectious body fluids such as:
    - Semen
    - Vaginal secretions
    - Any body fluid visibly contaminated with blood
    - Human tissues (including dental extractions)

Employee's Responsibility

- Needle-sticks, cuts and skin exposures should be washed with soap and water. (**Do NOT use bleach**)
- Splashes to the nose, mouth, or skin should be flushed with water.
- Splashes to the eyes should be irrigated with sterile irrigants, saline or clean water.
- Report the exposure to your supervisor right away. If HIV Post-exposure treatment is recommended, you should start treatment within 1-2 hours after the exposure or as soon as possible. (This can reduce HIV infection by up to 79%)

Supervisor's Responsibility

- Without delay – If a significant blood borne exposure has occurred, get the exposed individual to the nearest emergency room for evaluation. Supervisor should call the emergency room and informs them that they are sending an employee to the emergency room for evaluation and follow-up to a bloodborne exposure.
- Complete a "South Dakota Employer's First Report of Injury" and an "Employees Accident Report" for all bloodborne pathogen exposures. These forms must be completed and filed with the Workers Compensation Office/Bureau of Personnel within seven (7) days of the exposure/incident. An official written report is necessary for reporting the incident and to claim worker's compensation benefits for initial treatment and post exposure testing. If testing is refused this should also be reported. Report exposure to your next level supervisor.
- For additional information contact the Department of Health at **1-800-592-1861** or the check the comprehensive guidelines at http://intranet.state.sd.us/bop/index.htm
- Employees should be referred to the nearest Department of Health office for bloodborne pathogen counseling.

Healthcare Provider's Responsibility

- Determine the nature and severity of the exposure
- Evaluate source patient (if information is available)
- Counsel/treat exposed employee
- Also evaluate employee for Hepatitis B & C

Time is critical with this exposure. Know what you are going to do before an exposure occurs. When in doubt, report the exposure right away and seek guidance.

Supervisor's Checklist

Supervisor's Responsibility

- Supervisor should call the emergency room and inform them that they are sending an employee to the emergency room for evaluation and follow-up to a bloodborne exposure.

- Ensure that the source of the exposure, if known, is informed and that a specimen may be needed for testing.

- The "Occupational Risk Exposure Form" and the "Bloodborne Exposure Medical Follow-up Sheet" will be forwarded to the personnel office for inclusion in the employee's personnel file.

- As the employee receives treatment, the employee should be reminded to notify the personnel office of these treatments. The personnel office shall update the "Bloodborne Exposure Medical Follow-up Sheet"

HIV Post Exposure Testing Protocol

- Base Line Test
- Test 6 weeks after exposure
- Test 3 months after exposure
- Test 6 months after exposure
- Test 1 year after exposure (If Post Exposure Prophylaxis initiated with 2 or more drugs)

Hepatitis C Evaluation

Source Patient

- Baseline testing for Hepatitis C antibody (EIA)

Exposed Patient

- **Baseline and 6 month** testing for Hepatitis C antibody (EIA) and alanine aminotransferase activity *(liver enzymes)*
- Confirmation by supplemental anti-HCV testing of all anti-HCV results reported as repeatedly reactive by enzyme immunoassay (EIA)
- Educate patient about the risks for and prevention of bloodborne infections, including Hepatitis C
- **Not Recommended** is any post-exposure prophylaxis for Hepatitis C with immune globulin or anti-viral agents (e.g., interferon)

Reference: MMWR Notice to Readers Recommendations for Follow-up of Healthcare Workers After Occupational Exposure to Hepatitis C Virus, Jul 4, 97
http://www.cdc.gov/mmwr/PDF/wk/mm4626.pdf

Hepatitis B Evaluation Post Exposure Prophylaxis (PEP) Guide

- Draw Source Patient for Hepatitis B Surface Antigen
- raw Exposed Patient for Hepatitis B Surface Antibody and Surface Antigen

Summary Recommendations for Hepatitis B Prophylaxis Following Occupational Exposure			
Treatment when source is found to be:			
Exposed Person	**HBsAg-Positive**	**HBsAg-Negative**	**Source Not Tested**
Unvaccinated	*HBIG x 1 and initiate Hepatitis B Vaccine	Initiate Hepatitis B Vaccine	Intermediate or high risk: treat as though HGsAg-postive Low risk or risk unknown: HBIG optional, initiate Hepatitis B vaccine
Previously Vaccinated Known Responder	Test exposed for anti-HBs If adequate§, no treatment If inadequate, one dose Hepatitis B vaccine	No treatment	Intermediate or high risk: treat as though HBsAg-positive Low risk or risk unknown: anti-HBs testing optional
Known Nonresponder	*HBIG Stat. Repeat HBIG in 4 weeks	No treatment	Intermediate or high risk: treat as though HBsAg-positive Low risk or risk unknown: HBIG optional
Response Unknown	Test exposed for anti-HBs If adequate§, no treatment If inadequate, HBIG x 1 plus one dose Hepatitis B vaccine¶	**Test anti-HBs	Intermediate or high risk: treat as though HBsAg-positive Low risk or risk unknown: test anti-HBs** HBIG optional

* HBIG dose 0.06 ml/kg IM
§ Adequate anti-HBs = ≥ 10 mIU/mL
¶ Follow with repeat anti-HBs testing in 2-3 weeks. If less than 10 mIU/mL, repeat HBIG 4 weeks after initial dose
** If less than 10 mIU/mL, administer one dose Hepatitis B vaccine followed by repeat anti-HBs testing in 4 weeks.

Reference: MMWR Vol 46, No. RR-18, Dec 12, 1997
http://www.cdc.gov/ncidod/diseases/hepatitis/resource/PDFs/RR4618 22-23.pdf

OCCUPATIONAL RISK EXPOSURE REPORT FORM

PART I: Exposed Employee Section (please print)

Employee Name: _____ DOB ___/__/_____

(Last, First) (Month/Day/Year)

Job Title: _____Location of Exposure: _____

Date of Exposure ____/____/_____ Time of Exposure_____AM/PM

Number of Hepatitis B vaccinations previously received: None____ 1___ 2___ 3___

Previously Anti-HBs positive _____ Yes _____ No _____Unk

If Yes: result ≥ 10 mIU/mL _____ Yes _____ No _____ Unk

Description of incident (give specific details - Enter specific information (as applicable regarding the exposure incident):

- What the exposed employee was doing at the time the exposure occurred (i.e., (1) after drawing blood on a person requesting HIV testing, I was attempting to discard the needle into the sharps container; (2) I was assisting with a car accident, received a cut on my hand that was exposed to blood)

- How the exposure occurred (i.e., (1) sharps container was full and my hand slipped while forcing the needle into the container; (2) the victims blood entered the wound on my hand)

- What part of the body was exposed (i.e., (1) left index finger was punctured by the needle I was trying to dispose; (2) the palm of my hand)

- Contributing factors to the exposure (i.e., (1) there was no empty sharps container available in the clinic in which to dispose of the needle; (2) sharp metal and glass at the scene of the accident)

_____

_____

_____

_____

_____

PART II: Source Person Section

Source Person Known Yes _____ No _____ Complete remainder of form

Source Person Unknown Yes _____ No _____ Skip this section

Name of person or identifier:

_____
Last First Middle Initial

DOB ____/____/_____ Age_____ Sex: _____ M _____ F

Address:_____
Street City State Zip

Phone Numbers: Home ( ) _____

Work ( ) _____

Cell ( ) _____

Indicate if source person has any known history of bloodborne pathogens or risks for bloodborne pathogens.

_____
_____
_____
_____
_____
_____
_____

SOUTH DAKOTA DEPARTMENT OF HEALTH

Employee HIV Post-Exposure Prophylaxis (PEP) Decision Form

Employee Statement - to be completed if a physician or physician's designee indicates an exposure having the potential for HIV transmission occurred to a Department of Health employee.

I understand that due to my occupational exposure to blood or other potentially infectious materials which occurred on ___/___/___, that I may be at risk of acquiring HIV infection.

I understand the US Centers for Disease Control and Prevention (CDC) publishes recommendations concerning specific protocols for post-exposure prophylaxis that may decrease my risk of acquiring HIV infection. (*Post-exposure prophylaxis* means medications to help prevent disease which may be taken after an occupational exposure.) I also understand that the only published efficacy data for chemoprophylaxis, after occupational exposure to HIV, is for the drug Zidovudine (ZDU) and other drugs associated with a theoretical decrease of approximately 79% in the risk of HIV seroconversion after percutaneous exposure to HIV-infected blood in a case-control study among health care providers. (*Efficacy data for chemoprophylaxis* means studies showing prevention medications may be effective. *Percutaneous exposure* means becoming infected after exposure to a sharp object.)

I have been counseled to my satisfaction concerning my occupational exposure incident, associated risks of harm, CDC recommendations, and the physician's or physician's designee's recommendations concerning post-exposure.

I acknowledge that I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I also acknowledge that I have been given the opportunity to receive medications, free of charge, which may reduce my risk of acquiring HIV as a result of my occupational exposure incident.

_____ (Initial) **I accept PEP recommendations to take the medication regimen as prescribed.** If for some reason I cannot complete the recommended course of medication, I will promptly report this to my supervisor.

_____ (Initial) **I accept PEP recommendations to not take the medication regimen.**

_____ (Initial) **I refuse to accept PEP recommendations to take the medication regimen.**

Name:_____
(Please print)

Signed: _____ Date: _____/_____/_____
(Signature)

Witness: _____ Date: _____/_____/_____
(Signature)

BLOODBORNE EXPOSURE MEDICAL FOLLOW-UP SHEET

Source Person Blood Testing

Name or ID: _____

HIV Status:

___Pos ___ Neg ___ Not Done ___ Refused _____/_____/_____ If done, date drawn

If "Not Done", specify why:

_____

_____

_____

Hepatitis B Surface Ag:

___Pos ___ Neg ___ Not Done ___ Refused _____/____/_____ If done, date drawn

If "Not Done", specify why:

_____

_____

_____

Hepatitis C:

___Pos ___ Neg ___ Not Done ___ Refused _____/____/_____ If done, date drawn

If "Not Done", specify why:

_____

_____

_____

Employee Testing

Name or ID:_____

Hepatitis B Quantitative Anti-Hep B surface Antibody (for vaccinated employees only)

If done, date drawn _____ /_____/_____

Results: ____ ≥ 10 mIU/mL ____ less than 10 mIU/mL ___ Not Done ____ Refused

HIV Employee Testing:

Baseline: Date Drawn: _____/_____/_____

_____ Pos _____ Neg _____ Indeterminate _____ Not Done
Refused

Type Screening Test Done:_____

Type Confirmation Test Done:_____

6 weeks: Date Drawn: _____/_____/_____

_____ Pos _____ Neg _____ Indeterminate _____ Not Done
Refused

Type Screening Test Done:_____

Type Confirmation Test Done:_____

12 weeks: Date Drawn: _____/_____/_____

_____ Pos _____ Neg _____ Indeterminate _____ Not Done
Refused

Type Screening Test Done:_____

Type Confirmation Test Done:_____

6 months: Date Drawn: _____/_____/_____

_____ Pos _____ Neg _____ Indeterminate _____ Not Done
Refused

Type Screening Test Done:_____

Type Confirmation Test Done:_____

1 year: Date Drawn: _____/_____/_____

_____ Pos _____ Neg _____ Indeterminate _____ Not Done
Refused

Type Screening Test Done:_____

Type Confirmation Test Done:_____

Hepatitis C Employee Testing:

Baseline: Date Drawn: _____/_____/_____

_____ Pos _____ Neg _____ ALT _____ Not Done _____ Refused

6 month: Date Drawn: _____/_____/_____

_____ Pos _____ Neg _____ ALT _____ Not Done _____ Refused

Employee Treatment

Hepatitis B Immunoglobulin (HBIG):
_____ Yes _____ No _____ Refused If yes, date given _____/_____/_____

Hepatitis B Vaccine:

Dose 1: ____ Yes ____ No ____ Refused If yes, date given _____/ _____/ _____

Dose 2: ____ Yes ____ No ____ Refused If yes, date given _____/ _____/ _____

Dose 3: ____ Yes ____ No ____ Refused If yes, date given _____/ _____ /_____

HIV PEP (Post Exposure Prophylaxis)

Meds Started: _____ Yes ____ No ____ Refused If yes, date started ___/___/_____

Completed 4 weeks? _____ Yes _____ No Date ended _____/_____/_____

Medication Taken:

_____

_____

Specify any other medical treatment for this exposure:

_____

_____

_____

SOUTH DAKOTA DEPARTMENT OF HEALTH
SOURCE PERSON CONSENT FORM

I understand that it has been determined by a physician or physician's designee that a Department of Health employee has had a significant exposure to my blood or body fluids. The nature of my blood or body fluids exposure to the Department of Health employee has been explained to my satisfaction.

I understand that in order to make appropriate medical decisions for the Department of Health employee exposed to my blood or body fluids, the Department of Health is requesting that I voluntarily submit a blood specimen for bloodborne pathogens, Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV) testing. *The testing will be free of charge to me and all test results will be provided to:*

(a) my physician, or physician's designee, _____
_____

(b) the Department of Health employee's physician or physician's designee,
_____
_____; and

(c) the Department of Health.

I acknowledge that I was given an opportunity to ask questions about the exposure, how my blood specimen is to be provided, what tests will be performed, who is to receive copies of my test results, and any other questions I had. I understood all of the answers to my questions before making my decision below.

_____ **I consent to the Department of Health taking a blood specimen from**
(initial) **me, testing it, and releasing those test results as indicated above.**

OR

_____ **I refuse to allow the Department of Health to take a blood sample**
(initial) **from me.**

Name of Source Person: _____
(Please print)

Source Person Signature: _____
(date)

Witness: _____
(date)

South Dakota Employer's First Report of Injury
(See Instructions on Back of Form)

EMPLOYEE

SSN: _____ **Date of Birth:**_____ **Gender: M ☐ F ☐** **# Dependents:** _____

Name: _____
(Last) **(First)** **(Middle initial)**

Mailing Address: _____

City: _____ **State:** _____ **Zip:**_____ **Telephone No.:(____)**_____

Employee signature: (X) _____**Date**_____

Education:

☐ **Less than High School**
☐ **GED or High School**
☐ **Beyond High School**

INJURY/TREATMENT

Date of Injury: _____ **Time of Injury:** _____ **a.m./p.m.** **Fatality Date (if applicable):** _____

County Where Injury Occurred: _____ **Was Safety Equipment Provided? Yes ☐ or No ☐**

Time Work Day Began on Date of Injury: _____ **a.m./p.m.** **Was Safety Equipment Used? Yes ☐ or No ☐**

Date Returned to Work (if applicable): _____ **Did Injury Occur on Employer Premises? Yes ☐ or No ☐**

Address or Location of Injury: _____

Description of Injury: _____

_____

Date Employer Notified of Injury: _____

Injury Reported to: _____ **Witness:** _____

(See Codes on Reverse)

_____ **Body Part Injured**

(If code 90, Multiple Injury, please specify body part codes for each body part injured.)

_____ _____

_____ _____

_____ **Nature of Injury**

_____ **Cause of Injury**

Type of Treatment (please check one)
☐ **No Treatment**
☐ **On-Site Treatment**
☐ **Clinic**
☐ **Emergency Room**
☐ **Hospitalization**

If treatment sought, please specify provider of treatment:

Doctor, Clinic or Hospital Name: _____

Mailing Address: _____

City: _____ **State** _____ **Zip** _____ **Telephone No.: (_____)**_____

EMPLOYER/EMPLOYMENT INFORMATION:

Federal ID No.: _____ **# Employees:** _____

Employer Name (DBA): _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone No. : (_____)_____ **County Where Employer Located:** _____

Employer signature: _____**Date**_____

Employment Type: ☐ Regular or ☐ Temporary

Emp. Status: ☐FT ☐PT ☐Seasonal ☐Volunteer

Date Employee Hired: _____

Employee's Position: _____

Employee's Time in Current Position: _____

Employee's Hours Per Week: _____

Employee's Current Wage:

$ _____ per _____

CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business): _____

Carrier Code _____ **FEIN (Claim Office)** _____

Claim Office _____

Claim Office Address _____

City _____ **State** _____ **ZipCode** _____

Telephone _____

Email Address _____

Claim Office Claim # _____

Date Notified _____ **Date to DOL** _____

☐ Check if Claim Office is same as Insurance Provider

If not, you must complete the following
UNDERLYING INSURANCE PROVIDER INFORMATION

Carrier Code (If applicable) **FEIN (Insurance Provider)**

_____ _____

Represented Entity Name _____

Address _____

City _____ **State** _____ **Zip Code**_____

Telephone Number _____

Policy Number _____

Effective Dates _____

Adjuster / Contact Person _____

Submit form to: South Dakota Department of Labor
Division of Labor and Management
700 Governors Drive
Pierre, SD 57501-2291
Telephone (605) 773-3681

STATE OF SOUTH DAKOTA
BUREAU OF PERSONNEL
EMPLOYEE'S ACCIDENT REPORT

NAME: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

DATE OF INJURY: _____

TIME OF INJURY: _____

DESCRIBE DUTIES PERFORMED AT THE TIME OF THE INJURY: _____

_____

_____

LOCATION OF ACCIDENT OR INCIDENT: _____

_____

NATURE OF INJURIES: _____

WEATHER CONDITIONS: _____

MAINTENANCE INFORMATION/DESCRIBE UNSAFE CONDITION: _____

_____

_____

NAME AND ADDRESS OF DOCTOR, IF TREATED: _____

_____

HAVE YOU HAD SIMILAR PROBLEMS IN THE PAST: _____

LIST NAME, ADDRESS, AND PHONE NUMBER OF DOCTORS WHO TREATED YOU:

_____

_____

WITNESS: _____

EMPLOYEE'S SIGNATURE: _____ DATE: _____

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

EMPLOYER

1. Complete all questions in the EMPLOYER/EMPLOYMENT sections.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of the injury, as required by SDCL 62-6-2.
4. Give a copy of the form to the injured employee.
5. Keep the copy of the First Report of Injury for at least four (4) years from the date of injury, as required by SDCL 62-6-1.

INSURER

1. Complete all questions in the CLAIM OFFICE INFORMATION sections at the bottom of the page.
2. Submit this form within ten (10) days of its receipt, as required by SDCL 62-6-3, to:

SOUTH DAKOTA DEPARTMENT OF LABOR
Division of Labor and Management
700 Governors Drive
Pierre SD 57501-2291

Tel. (605) 773-3681

BODY PART CODES

02	Blindness one eye	44	Chest, including ribs sternum, soft ribs	78	Ring finger at metacarpal bone
03	Blindness both eyes	48	Internal organs-other than heart, lungs	79	Ring finger at proximal joint
04	Deafness both ears	49	Heart	80	Ring finger at middle joint
05	Deafness one ear	51	Hip	81	Ring finger at distal joint
10	Multiple head injury	52	Upper leg	82	Little finger at metacarpal bone
11	Skull	53	Knee	83	Little finger at proximal joint
12	Brain	54	Lower leg	84	Little finger at middle joint
13	Ear(s)	55	Ankle	85	Little finger at distal joint
14	Eye(s)	56	Foot	86	Great toe metatarsal bone
17	Mouth	57	Toe (other than greater)	87	Great toe at proximal joint
19	Face (facial bones)	58	Toe (greater)	88	Great toe at distal joint
20	Multiple neck injury	60	Lungs	90	Multiple injury
21	Vertebrae	61	Groin	92	Other toe metatarsal bone
22	Disc	67	Thumb metacarpal bone	93	Other toe at proximal joint
24	Other	68	Thumb at proximal joint	94	Other toe at middle joint
31	Upper arm	69	Thumb at distal joint	95	Other toe at distal joint
32	Elbow	70	Index finger at metacarpal bone	96	Little toe metatarsal bone
33	Lower Arm-forearm	71	Index finger at proximal joint	97	Little toe at distal joint
34	Wrist	72	Index finger at middle joint		
35	Hand	73	Index finger at distal joint		
37	Thumb	74	Middle finger at metacarpal bone		
38	Shoulder	75	Middle finger at proximal joint		
41	Upper Back	76	Middle finger at middle joint		
42	Lower Back	77	Middle finger at distal joint		

Cause of Injury Codes

01	Body reaction/over reaction (includes chemicals)	70	Striking against or stepping on
03	Temperature extremes	78	Struck or injured by moving parts of machine
13	Caught in/under/between	81	Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc.
25	Fall from elevation	89	Hostile attack-person in act of crime
29	Fall from same level	90	Other than physical cause of injury
50	Motor vehicle	94	Repetitive motion – callous, blister, etc.
56	Bending/Lifting	97	Repetitive motion-carpal tunnel syndrome, etc.
65	Machinery/Equipment	99	Other

Nature of injury codes

00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss